



**Health Spending Account Claims Authorization**

to reduce the Administration expenses, please submit Claims Forms when the Total Claims are at least \$100

Name of the Employer

\_\_\_\_\_

Employee's Last Name	First Name	Initials	Single or Family	Benefit Class
_____	_____	_____	_____	_____

**Employee Reimbursement**

use one Summary of Claims line (below) for all Claims if for the same Claimant and enter relation to Employee

Last Name of Claimant	First Name	Relationship to Employee	Amount of Claim
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Sub-total: Reimbursement to Employee

\_\_\_\_\_

**Service Provider Payment**

use one Summary of Claims line (below) for all Claims if for the same Claimant and the same Service Provider

Last Name of Claimant	First Name	Name of Service Provider	Amount of Claim
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Sub-total: Payment to Service Providers

\_\_\_\_\_

**Calculation and Payment**

Total Claims:

\_\_\_\_\_

\_\_\_\_\_

signature of eligible Employee

date of signature

**Instructions**

Retain Copies of Claims, Receipts and Statements  
Send Originals for Payment to Assureflex Corporation  
Post Office Box 81, Strathroy, Ontario N7G 3J1